



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: DR ALLEN S KENT 800 12 TH AVENUE SUITE 200 FORT WORTH TX 76104	MFDR Tracking #: M4-07-4824-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: LIBERTY MUTUAL FIRE INSURANCE Box #: 01	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Denied unlisted procedure is not included in any other service provided during surgery. We are entitled to reimbursement."

Amount in Dispute: \$1500.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Per the CPT code book CPT 23929 represents 'unlisted procedure shoulder'." "The provider letter states they are using this miscellaneous CPT code 23929 to represent a Tissue Graft Patch." "This procedure Autologous Platelet Concentrate tissue graft patch is included in the procedures performed per Medicare CCI ... Medicare CCI allows billing for a separate graft if it is performed through a separate incision. In this case it was not performed through a separate incision."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Denial Code(s)	Amount in Dispute	Amount Due
8/25/2006	23929-RT	97, X212, W1, Z346	\$1500.00	\$0.00
			Total Due:	\$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
2. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
3. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment and services.
4. Division rule at 28 TAC §133.307, effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007 sets out the procedure for medical fee dispute resolution.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 10/9/2006

- 97, X212-This procedure is included in another procedure performed on this date.
- W1-Workers Compensation state fee schedule adjustment.
- Z346-Right side.

Explanation of benefits dated 3/12/2007

- 97, X212-This procedure is included in another procedure performed on this date.
- W1-Workers Compensation state fee schedule adjustment.
- Z346-Right side.

Issues

1. Is the respondent's denial code of "97" and "X212" supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Division rule at 28 TAC §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program methodologies, models, and values or weight including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

The respondent denied reimbursement of CPT code 23929-"User Defined (description not available)" based upon the procedure being included in another procedure performed on this date. Based upon the submitted documentation, the requestor used CPT code 23929 for autologous platelet concentrate tissue graft patch.

The August 25, 2006 Operative report indicates that the claimant underwent the following procedures:

- Right shoulder arthroscopic acromioplasty.
- Right shoulder extensive scar resection and debridement.
- Right shoulder autologous tissue graft patch.

On the disputed date, the requestor billed the respondent for CPT codes 23929-RT, 29823-RT, 29826-RT and 99080-73. Per NCCI edits, CPT code 23929 is not a component of any of the other procedures performed on this date; therefore, the respondent's denial codes of "97" and "X212" are not supported.

2. Division rule at 28 TAC §134.202(c)(1) states "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used."

Division rule at 28 TAC §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." The Division finds that CPT code 23929 does not have an established relative value and the insurance carrier did not submit documentation to support that the carrier has assigned a relative value.

Division rule at 28 TAC §134.202(d) states "In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)."

Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated and/or contracted between the provider and carrier for the disputed CPT code 23929; therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate in accordance with Division rule at 28 TAC §134.1.

Division rule at 28 TAC §134.1 which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and

paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Division rule at 28 TAC §133.307(g)(3)(D) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor's position statement states that "Denied unlisted procedure is not included in any other service provided during surgery. We are entitled to reimbursement."
- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor does not discuss or explain how payment of \$1500.00 would result in a fair and reasonable reimbursement.
- The requestor did not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the proposed methodology.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the requestor's position that CPT code 23929 is not a component of any other procedure performed on this date. For the reasons stated above, the division finds that the requestor has not established that amount billed is fair and reasonable per Division rule at 28 TAC §133.307(g)(3)(D), §134.1, and Texas Labor Code §413.011(d). As a result, the amount ordered is \$0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

Medical Fee Dispute Resolution Officer

01/06/2011

Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.